

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2013
NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for an investigation of Complaint IN00127513 and Complaint IN00131536.</p> <p>Complaint IN00127513 -Unsubstantiated due to lack of evidence Complaint IN 00131536 -Unsubstantiated due to lack of evidence</p> <p>Survey Date: July 15 and July 16 2013</p> <p>Facility number: 000168 Provider number: 155267 AIM number: 100267020</p> <p>Survey team: Gwen Pumphrey, RN(TC) Gloria Reisert, MSW Nicole Wright, RN</p> <p>Census bed type: SNF:0 NF:0 SNF/NF:56 Residential:0 Total: 56</p> <p>Census payor type: Medicare:10 Medicaid: 43 Private: 3 Other:0 Total: 56</p> <p>Sample: 15</p> <p>Scott Villa Nursing and Rehabilitation Center was</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to Investigation of Complaint IN00127513 and Complaint IN00131536. Quality Review 08/07/13 by Lisa McColly	F 000			